The State Health Plan

State Health Plan Contents

Your State Health Plan in 2005:
More choices, more options, more savings

The State Health Plan provides you and your family with valuable medical coverage if you become sick or injured. With the Plan, you have extensive coverage when you need it most.

The State Health Plan is a self-insured medical plan. Because we are self-insured, the Employee Insurance Program (EIP) determines the Plan's coverage and benefits. EIP does not pay premiums to an insurance company. Your monthly premium, combined with all other premiums and your employer's contribution, is placed in a trust account maintained by the state to pay claims and administrative costs. Any interest earned from this trust account is used to help fund the Plan.

In 2005, the State Health Plan is projected to pay more than $1 billion in claims for its subscribers. To administer the Plan, we have contracted with companies such as BlueCross BlueShield of South Carolina to process medical claims, APS Healthcare, Inc., to process mental health and substance abuse claims and Medco to process prescription drug claims. Less than four percent of our budget goes to pay these claims processors. See page 30 to learn more about your benefits.

This chapter is a short description of the State Health Plan Standard Plan and Savings Plan. To make it easier to find information, it has been divided into sections, such as:

The *Plan of Benefits* document contains a complete description of the Plan. Its terms and conditions govern all health benefits offered by the state. If you would like to review this document, contact your benefits administrator or the Employee Insurance Program. Check the premium section beginning on page 211 to learn about the rates for each plan.

Enrolling in the State Health Plan

Initial Enrollment

If you are an eligible employee (see definition on page 226) of a participating employer in South Carolina, you can enroll in the Plan within 31 days of the date you are hired. To enroll, you must complete the required forms, including a Notice of Election (NOE) form. Coverage is not automatic. You also can enroll your eligible dependents.

After you enroll, you should check your payroll stub to make sure the correct amount is being deducted. Your coverage will continue from one year to the next as long as you are a full-time, permanent employee. Your coverage begins on the first day of the month coinciding with, or following, the date you begin employment and are actively at work. Coverage for your enrolled dependents begins when your coverage becomes effective.

Late Entry

If you do not enroll within 31 days of the date you begin employment, you cannot enroll yourself and your dependents until the next open enrollment period or within 31 days of a special eligibility situation. Open enrollment is held in odd-numbered years. The next open enrollment will be in October 2005.

Changing Plans

You can change from the Savings plan to the Standard plan or vice versa only during enrollment periods. There may be exceptions to this rule. Contact your benefits administrator for details.

Marriage

If you wish to add a dependent spouse and/or child because you marry, you can add him by completing an NOE within 31 days of the date of your marriage. Coverage becomes effective with the date of marriage. You cannot cover your spouse as a dependent if he is eligible, or becomes eligible, for coverage as an employee or retiree of a state-covered employer (exceptions may apply). If you do not add him within 31 days of the date of marriage, you cannot add him until the next open enrollment period (or within 31 days of a special eligibility situation).

If you divorce, you must drop your spouse from your coverage by completing an NOE within 31 days of the date the divorce decree is signed, unless you are legally required to cover him by court order or the terms of the divorce decree. Your divorced spouse's coverage ends the last day of the month in which the divorce decree is signed. If you remarry, you can cover your divorced spouse or your current spouse, but you cannot cover both.

You can continue to cover your children if they live with you and you are financially responsible for them, or if you are legally required to cover them. Dependents who lose coverage may be eligible to continue coverage under COBRA. For more information, contact your benefits administrator or EIP within 60 days of the loss of coverage.

Adding Children

Eligible children may be added by completing an NOE within 31 days of the date of birth (notification to Medi-Call of the delivery of your baby does <u>not</u> add the baby to your health insurance), gaining custody, adoption or placement. Children

must be listed on your NOE to be covered by the State Health Plan, even if you already have family coverage. If your spouse is also a state employee, only one of you can cover your children.

Full-time Students

You can cover your dependent children, ages 19 through 24, who are full-time students. They must meet these requirements:

- Students must be enrolled in and attending an accredited high school, vocational/trade school or college/university *full-time*, as defined by the institution they attend.
- While summer school is not required for maintaining student status, dependents who enroll in summer school full-time may become eligible. However, they will lose eligibility if they do not re-enroll full-time the next semester/quarter.
- Adult education night classes and correspondence courses do not constitute full-time attendance.

EIP will send a Student Certification letter to your benefits administrator about 90 days before your dependent's 19th birthday. To continue coverage, this form letter must be completed and returned to EIP within 31 days of the child's 19th birthday, along with verification (on letterhead from the institution he is attending) that he is a full-time student. If the child's 19th birthday occurs during the summer, return the Student Certification letter to EIP with the "Pending Student Certification" block marked. You must submit a letter from the institution by September 30 verifying that your child is a full-time student.

If your dependent, age 19-24, goes back to school full-time, you may again add him to your health coverage. To do so, submit a Notice of Election (NOE) form and a verification of student status on letterhead from the institution, within 31 days of eligibility (in this case, the date he is again a full-time student).

If your child is covered as a full-time student, his eligibility for coverage ends the last day of the month in which he turns age 25, unless he is covered as an incapacitated dependent. It will be your responsibility to notify your benefits office that the child no longer is a full-time student.

EIP conducts periodic reviews of the eligibility of covered dependents between the ages of 19 and 24. If your child is found to be ineligible, his coverage will be cancelled, and EIP may seek repayment of any benefits paid for him when he was ineligible.

If your child is **not** a full-time student, his eligibility for coverage ends the last day of the month in which he turns 19, unless he is covered as an incapacitated dependent. Your dependent child's eligibility for coverage also will end if he gets married or obtains employment with benefits.

Incapacitated Child

You can continue to cover your child, who is age 19 or older, if he is incapacitated and you are financially responsible for him. To cover your dependent child who is incapacitated, he must meet these requirements:

- The child must be covered at the time of incapacitation.

- The child must be unmarried to be eligible and must remain unmarried to continue eligibility.
- The child must be incapable of self-sustaining employment because of mental illness, retardation or physical handicap, remaining principally dependent on the covered employee, retiree, survivor or COBRA subscriber for support and maintenance.

Incapacitation must be established within 31 days of the child's 19th birthday or within 31 days of the date he is no longer a student. An Incapacitated Child Certification Form must be completed by the subscriber and the attending physician and then sent to EIP for review.

Gaining Other Coverage

If you or your dependents gain other group coverage, you have 31 days to make a coverage change by completing an NOE and returning it to your benefits office with proof that coverage has been gained. If you fail to make a coverage change within 31 days, you must wait until the next open enrollment period. For more details, contact your benefits administrator or EIP.

Loss of Other Coverage

If you or your dependents are covered under another health insurance plan and you lose that coverage involuntarily because it was discontinued or the covered employee left employment, you have 31 days from the last day of coverage to enroll in the Plan. To enroll, you must complete an NOE and return it to your benefits office with proof that the health insurance was discontinued. Dependents must also be listed on the NOE in order to be covered, and the documentation of loss of coverage must indicate who was covered. If you fail to enroll within the 31 days, you must wait to enroll in the Plan until the next open enrollment period or within 31 days of a special eligibility situation.

Leave Without Pay

You can continue your coverage for up to 12 months if you are on leave without pay, as long as you pay the required premiums. Leave must be approved by your employer or must be a result of injury or sickness. *(For information on Family and Medical Leave, contact your benefits administrator.)*

Turning 65

The Social Security Administration should notify you of your eligibility for Medicare about 90 days before you turn 65 or when you become eligible due to a disability. If you are not notified, contact your local Social Security office. If you are already receiving Social Security benefits when you turn 65, Medicare Part A and Part B start automatically. If you are not receiving Social Security, you should sign up for Medicare before your 65th birthday, even if you are not ready to retire.

If You are an Active Employee

If you are actively working and/or covered under a state health plan for active employees, you do not need to sign up for Part B because your insurance as an active employee remains primary while you are working. However, if you are planning to retire within three months of age 65, you should contact Social Security to learn about your enrollment options. When you do retire, remember that you should sign up for Part B within 31 days of retirement, because Medicare will then be your primary coverage.

When Your Coverage Ends

Your SHP coverage will end:

- The last day of the month you leave your employment
- The last day of the month you enter a class of employees not eligible for coverage (for example, a change from full-time to part-time status)
- The day after your death
- The date the SHP ends for all employees or
- If you do not pay a required premium when it is due. (For example, if you are on leave without pay or on COBRA and are paying the full cost, you must make a monthly payment.)

Dependent coverage will end:

- The date your coverage ends
- The date dependent coverage is no longer offered by the State Health Plan or
- The last day of the month your dependent is no longer eligible for coverage

If your coverage or your dependent's coverage ends, you may be eligible for continuation of coverage as a retiree or survivor or under COBRA. If you are dropping a dependent from your SHP coverage, you must complete an NOE within 31 days of the date the dependent is no longer eligible for coverage.

COBRA

COBRA is short for the Consolidated Omnibus Budget Reconciliation Act. It requires that continuation of group insurance coverage be offered to you and your covered dependents if you are no longer eligible for coverage under this Plan.

You can continue your coverage for a limited time under COBRA if you and/or your covered dependents lose coverage because:

- Your working hours are reduced from full-time to part-time
- You voluntarily quit work, are laid off or are fired (unless the firing is due to gross misconduct)
- You are a separated or divorced spouse or
- You are no longer eligible as a dependent child

It is your responsibility to notify your benefits office within 60 days of the date you become divorced or separated or the date your dependent child becomes ineligible for coverage.

To continue coverage under COBRA, you must complete and return an NOE to EIP within 60 days of the loss of coverage or notification of the right to continue coverage, whichever is later.

COBRA coverage does not become effective until premiums are paid. If you need more information about COBRA, contact your benefits office or EIP.

Conversion

The Health Insurance Portability and Accountability Act of 1996 guarantees that persons, who have exhausted COBRA benefits and are not eligible for coverage under another group health plan, have access to health insurance coverage with out being subjected to a pre-existing condition exclusion period, assuming that certain conditions have been met. In South Carolina, this guarantee of health insurance coverage is provided by the South Carolina Health Insurance Pool. For

information regarding this coverage, call 800-868-2500, ext. 42757, or 803-788-0500, ext. 42757, in Columbia.

Death of an Employee or Retiree

If an active employee dies, you as a surviving family member should contact the deceased's employer to report the death, end the employee's health coverage and start survivor coverage (if applicable). If a retiree dies, you should contact EIP.

Survivors

If you are a covered spouse or child of either a deceased employee or a deceased retiree covered by the Plan, you can continue your SHP coverage. If you are classified as a survivor, your Plan premium will be waived for the first year after the employee's or retiree's death.

This waiver applies to survivors of all state agency and school district employees and retirees, as well as to survivors of employees of participating local subdivisions. Local subdivisions may elect to but are not required to waive the premiums of survivors of retirees. After the first year, a survivor must pay the full premium to continue coverage. If you and your spouse are both state employees or retirees at the time of death, the surviving spouse is not eligible for the waiver of premium benefit.

If you and/or your dependent children are covered at the time of the death of the employee or retiree, your coverage will be continued automatically. However, if you are the survivor of an active or retired employee and were not covered at the time of his death, you must apply to EIP within 31 days of his death or you must wait until the next open enrollment period to enroll as a late entrant. Contact EIP for more information.

If you are a covered spouse or dependent child of a covered employee, who was killed in the line of duty after December 31, 2001, and while working for a participating employer, your Plan premium will be waived for the first year after the employee's death. Following the one-year waiver, you may continue coverage, *at the employer-funded rate*, as long as you are eligible. Local subdivisions may elect to but are not required to contribute to your insurance coverage, but you may continue coverage, at the full rate, for as long as you are eligible.

As a surviving spouse you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. Contact EIP for details.

Your State Health Plan at a Glance

The State Health Plan offers two choices: the **Standard Plan** and the **Savings Plan**. Regardless of which plan you choose, it is important that you understand how your plan works.

The Savings Plan is new in 2005. If you are willing to take greater responsibility for your health and accept a higher annual deductible, you can save money on premiums. Because it is a tax-qualified, high-deductible health plan, eligible subscribers who enroll in the Savings Plan and who have *no other health coverage, including Medicare,* may establish a Health Savings Account, which can be used to pay qualified medical expenses now and in the future.

- Each plan has its own cost-sharing provisions. With the Standard Plan, the annual deductibles are lower, but the premiums are higher. After you reach your deductible, you pay your coinsurance for allowable charges until you reach your coinsurance maximum. Afterward, the Standard Plan pays 100 percent of allowable charges. There are also per-occurrence deductibles that you pay for certain services, in addition to your coinsurance.

  With the Savings Plan, the annual deductibles are much higher, but the premiums are much lower. After you reach your deductible, you pay your coinsurance for allowable charges until you reach your coinsurance maximum. Afterward, the Savings Plan pays 100 percent of allowable charges. However, with the Savings Plan, charges for out-of-network services do not apply to this maximum. There are no additional per-occurrence deductibles to pay with the Savings Plan.

- Both plans offer comprehensive medical coverage, which includes emergency room visits and hospitalization, physical therapy, physician visits, specialist care and much more.

- Both plans offer coverage for mental health and substance abuse. The deductibles and coinsurance for this coverage are the same as for any medical coverage. There are no inpatient day limits or outpatient visit limits as long as you get pre-authorization for these services and use a provider in the mental health and substance abuse network.

- Both plans offer prescription drug coverage. Under the Standard Plan, prescription drug coverage is separate from medical coverage; you pay a copayment for your prescription drugs. Prescription drug copayments do not apply toward the coinsurance maximum.

  Under the Savings Plan, you pay the full cost of the drugs until you reach your annual deductible; afterward, you are reimbursed for the plan's coinsurance amount on drug purchases. Your prescription drug coinsurance amounts apply toward the coinsurance maximum.

  Both plans have a generic drug provision. You will save money when you pur-

chase a generic drug, when available, and avoid any penalty for choosing a more expensive brand-name drug over its generic equivalent. For more information on prescription drug coverage with these plans, see pages 39-42.

- Both plans offer preventive care features, such well child visits, routine mammograms and health screenings. The Savings Plan offers even more preventive benefits, including an annual physical, an annual flu shot and access to a nurseline and self-care guide.

- Both have extensive provider networks in the state and around the world. By using a network provider, you not only save money, but you also ensure you are not charged more than what the plan allows. Network providers also file your claims for you.

- Both plans require you to receive authorization before having certain procedures done. By calling to pre-authorize those procedures, you ensure you and your family members are covered for the most appropriate medical care. For medical pre-authorization, call Medi-Call. Call for any hospital admission or if you become pregnant. There are penalties for not calling Medi-Call as required. APS Healthcare must pre-authorize all mental health or substance abuse services, or those services will not be covered. Be sure to read about these pre-authorization requirements, which are explained in more detail on pages 26-27 and 43-44.

  The Employee Insurance Program hires companies to administer the different parts of the State Health Plan. Each has its own Web site, where you can learn more about your benefits and find other health-related information. Refer to pages 49-50 for a list of these companies and their contact information.

This is a brief overview of your medical plan and is for comparison purposes only. The *Plan of Benefits* document governs all health benefits offered by the state.

	Standard Plan	Savings Plan
Annual Deductible	$350 Individual $700 Family	$3,000 Individual $6,000 Family
Per-occurrence Deductibles:		
Emergency Care[1]	$125	None
Outpatient Hospital[2]	$75	None
Outpatient Office Visit	$10	None
Coinsurance		
Network	20% You Pay 80% State Pays	20% You Pay 80% State Pays
Out-of-network	40% You Pay 60% State Pays	40% You Pay 60% State Pays
Coinsurance Maximum		
Network	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Out-of-network	$4,000 Individual $8,000 Family	None
Lifetime Maximum	$1,000,000	$1,000,000
Prescription Drug Deductible per Year	No Annual Deductible	You pay the full allowable cost for prescription drugs, and the cost is applied to your annual deductible.
Retail Copayments for up to a 31-day Supply **Mail Order Copayments for up to a 90-day Supply**	$10 generic $25 preferred brand $40 non-preferred brand $25 generic $62 preferred brand $100 non-preferred brand	After you reach your deductible, you continue to pay the full allowable cost for prescription drugs. However, the plan will reimburse you for 80 percent of the allowable cost of your prescription. You pay the remaining 20 percent as coinsurance.
Coinsurance Maximum	$2,500 per person (applies to prescription drugs only)	Drug costs are applied to your plan's coinsurance maximum: $2,000 – individual; $4,000 - family. After the coinsurance maximum is met, the plan pays 100 percent of covered allowable costs.
Tax-favored Medical Accounts	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

[1]*Waived if admitted.*
[2]*Waived for dialysis, routine mammograms, routine pap smears, clinic visits, ER, oncology, electro-convulsive therapy, psychiatric medication management and physical therapy visits.*

How SHP Benefits are Paid

State Health Plan subscribers share in the cost of their covered benefits by paying deductibles and coinsurance for medical and behavioral health services and, with the Standard Plan, copayments, including those for prescription drugs and outpatient office visits. This is how you contribute to keeping premiums low and preserving benefits. All subscribers enrolled in the State Health Plan are responsible for paying:

Annual Deductible

The annual deductible is the amount of covered expenses (including mental health and substance abuse expenses) you must pay each year before the Plan begins to pay benefits. The annual deductibles are:

Standard Plan	$350 for individual coverage $700 for family coverage
Savings Plan	$3,000 for individual coverage $6,000 for family coverage

Standard Plan

Under the Standard Plan, the family deductible is the same, regardless of how many family members are covered. For example, if you have the Standard Plan employee-only coverage, once you pay the $350 deductible, you will begin receiving benefits. However, if you have the Standard Plan family coverage, once any one person has paid the $350 individual deductible, he will begin receiving benefits. No one family member may pay more than $350 toward the $700 family deductible.

For the other family members to begin receiving benefits, either their individual $350 deductible, the $700 family deductible or a combination of individual deductibles totaling $700 must be met. For example, if seven people each have $100 in covered expenses, the family deductible has been met, even if no one person has met the $350 individual deductible. If the employee and his spouse covered as an employee wish to share the same plan family deductible, both spouses must select the same health plan.

If you are covered under the Standard Plan, you pay copayments for drugs up to a maximum of $2,500. Your drug costs do not apply to your deductible.

Savings Plan

There is no individual deductible if more than one family member is covered. The family deductible is not considered met for any individual covered until total medical expenses exceed $6,000. For example, even if one family member has $3,001 in covered medical expenses, he will not begin receiving benefits until his family has $6,000 in covered expenses. However, if the subscriber has $1,000 in expenses, the spouse has $3,001 in expenses and another child has $2,000 in expenses, all family members will begin receiving benefits.

If you are covered under the Savings Plan, you pay the full allowable cost for prescription drugs, and their cost will be applied to your deductible.

Per-occurrence Deductibles

Standard Plan
This is the amount you must pay before the Standard Plan begins to pay benefits each time you have an emergency room or outpatient hospital service. It does not apply to the out-of-pocket maximum.

The deductible for each emergency room visit is $125. This deductible is waived if you are admitted to the hospital.

The deductible for each outpatient hospital service is $75. This deductible is waived for dialysis, routine mammograms, routine pap tests, clinic visits (an office visit at an outpatient facility); emergency room, oncology, electro-convulsive therapy, psychiatric medication management and physical therapy visits. Outpatient facility services for psychiatric diagnoses must be provided at an APS network facility to be covered, and clinic visits for mental health services are not covered.

Savings Plan
There are **no** per-occurrence deductibles under the Savings Plan. You pay the full allowable cost for services, and it is applied to your annual deductible.

Per-visit Deductibles

Standard Plan
You must pay a $10 per-visit deductible each time you receive services in a professional provider's office. It does not apply to the out-of-pocket maximum. This deductible is waived for routine pap tests, routine mammograms and well child care visits. Here's an example of how the per-visit deductible works:

- If the SHP Standard Plan allowed $49 for an office visit, you would first pay the $10 per-visit deductible. Then, if you have not met your annual deductible, the remaining $39 would apply toward meeting your annual deductible. (Your total bill would be $49.)
- If you have met your annual deductible, the Standard Plan would pay 80 percent of the $39, or $31.20, and you would be responsible for the remaining $7.80. (Your total bill would be $17.80.)

Savings Plan
There are no per-visit deductibles under the Savings Plan. You pay the full allowable cost of the service, and it is applied to your annual deductible.

Coinsurance

Standard Plan
After your annual deductible has been met, the Standard Plan pays 80 percent of your covered medical, mental health and substance abuse expenses if you use network providers. You pay the remaining 20 percent. If you use non-network providers, the Plan pays 60 percent of your covered expenses. You pay the remaining 40 percent. This is applied to your coinsurance maximum. However, even after you meet your annual deductible under the Standard Plan, per-occurrence and per-visit deductibles still apply.

Savings Plan
After your annual deductible has been met, the Savings Plan pays 80 percent of your covered medical, prescription drug, mental health and substance abuse expenses if you use network providers. You pay the remaining 20 percent. The amount you pay to network providers contributes to your coinsurance maximum. If you use non-network providers, the Plan pays 60 percent of your covered expenses. You pay the remaining 40 percent. Under the Savings Plan, there is no coinsurance maximum on the services of non-network providers.

Under Both Plans
A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility (see pages 31-32).

If you use a non-network provider, any charge above the Plan's allowable amount for a covered medical expense is your responsibility. You will also have to pay the additional 20 percent in coinsurance. See page 22 to learn more about this "out-of-network differential." If you use a non-network provider for prescription drugs or mental health or substance abuse services no benefits will be paid.

Coinsurance Maximum

Standard Plan
The maximum amount you must pay each year in coinsurance under the Standard Plan is $2,000 for individual coverage or $4,000 for family coverage for network services and $4,000 for individual coverage and $8,000 for family coverage for non-network services. The State Health Plan will then pay 100 percent of the allowable expenses. Expenses you pay for non-covered services, prescription drugs, deductibles, or penalties for not calling Medi-Call or APS Healthcare do not count toward your coinsurance maximum.

Savings Plan
The amount you must pay each year in coinsurance under the Savings Plan is $2,000 for individual coverage and $4,000 for employee/spouse, employee/children and full-family coverage for network services. The State Health Plan will then pay 100 percent of the allowable cost of your covered expenses. This limit does not include expenses for non-covered services, the annual deductible or penalties for not calling Medi-Call or APS Healthcare. If you use non-network providers, there is **no limit** on the amount of coinsurance you must pay.

Lifetime Maximum

The maximum amount the Plan will pay for each person for all benefits is $1,000,000. The lifetime maximum for each person includes all payments made for a person while covered under any State Health Plan option (Savings, Economy, Standard, or Medicare Supplemental plans), regardless of any break in coverage or whether the person is enrolled in one of the plans as a dependent, an employee or a retiree.

Coordination of Benefits

The benefits provided under the State Health Plan are subject to coordination of benefits (COB). On January 1, 2005, the State Health Plan began coordinating retail prescription drug benefits at the point of sale. The Plan already coordinates other health benefits, so this provision is not new to State Health Plan subscribers.

When a subscriber has health coverage under more than one health plan, he can file a claim for reimbursement from both plans. Plan administrators, such as BlueCross Blue Shield of South Carolina, Medco and APS Healthcare, Inc., coordinate benefits so that you get the maximum amount allowed. That amount will never exceed 100 percent of your covered medical or prescription drug expenses.

If the COB provisions apply, there are rules that determine whether the benefits of the State Health Plan are applied before or after those of another plan. When you are covered by more than one plan, the plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. Here are some examples of how that works:

- The plan that covers a person as an employee is primary to the plan that covers the person as a dependent.

- When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is considered primary.

- If you are eligible for Medicare and are covered under the active employee group, the SHP is primary over Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.

- The benefits of the SHP are not reduced when the SHP is primary, but may be reduced when the SHP is determined to be the secondary payer.

- If the SHP is the secondary payer for a medical claim, you must file the Explanation of Benefits from your primary plan directly with BlueCross BlueShield of South Carolina.

- If the SHP is the secondary payer for mental health and substance abuse benefits, claims should be filed with APS Healthcare, Inc.

- If the SHP is the secondary payer for prescription drug benefits, when you visit the pharmacy, you should present the card for your primary coverage first. If you present your SHP card first, the claim will be rejected because the pharmacist's electronic system will indicate that the SHP is secondary coverage. After the pharmacy processes the claim through your primary coverage, it must be processed through the SHP for any secondary benefits to be paid. You will need to file a paper claim with Medco for any SHP benefits. Prescription drug claim forms are available on the EIP Web site at www.eip.sc.gov. Choose your category, then click on "Forms."

- Please remember: The SHP is not responsible for filing or processing claims for a subscriber through another health insurance plan. That is your responsibility.

Subrogation

The SHP has the right to recover damages against a liable third party to the extent of benefits paid for medical expenses. In other words, when your injury was the caused by a third party, the Plan will seek compensation for medical expenses from the third party who caused the injury. If you receive payment for these medical expenses from another person, firm, corporation or business, you agree to reimburse the Plan in full for any medical expenses paid by the Plan.

Workers' Compensation

The Plan is not in lieu of Workers' Compensation and does not affect any requirement for coverage for Workers' Compensation insurance. It is not intended to provide or duplicate benefits for work-related injuries that are within the Workers' Compensation Act. If you need more information, please contact your benefits office or EIP.

Using SHP Provider Networks

Preferred Provider Organization

The State Health Plan (SHP) is a preferred provider organization (PPO). It has arrangements with doctors, hospitals and other healthcare providers who have agreed, as part of our networks, to accept the Plan's allowable charges for covered medical services as payment in full and will not balance bill you. However, the choice is yours. When you need care, you decide which doctor will take care of you.

This applies to your medical benefits only. Prescription drug and mental health and substance abuse benefits are not paid if you do not use a network provider.

Medical Care

Medical providers include networks of physicians, hospitals, mammography testing centers and ambulatory surgery centers.

Physician Network

If you need to see a medical doctor, you may benefit from using the SHP Physician Network. All eligible doctors in South Carolina are invited to participate. Doctors who have agreed to participate accept the Plan's allowable charges for covered medical services as payment in full. See "How SHP Benefits are Paid" on page 14 for information on applicable deductibles and coinsurance.

Hospital Network

The hospital network applies to all inpatient and outpatient hospital services. All general hospitals in South Carolina participate in the SHP hospital network. See "How SHP Benefits are Paid" on page 14 for information on applicable deductibles and coinsurance.

How to Find a Network Provider

The SHP's provider networks are available on the Internet.

The easiest way to see the list of network medical providers is to go to EIP's Web site, www.eip.sc.gov. Choose your category and then select "Online Directories." Choose "State Health Plan Doctors/Hospital Finder."

At the site, you will find a list of network providers who will care for you when you need any of these services:

- Allergy
- Anesthesiology
- Cardiology (Heart and Blood Vessels)
- Chiropractic
- CNM (Certified Nurse Midwife)
- CRNA (Nurse Anesthetist)
- Dermatology (Skin Diseases)
- Endocrinology (Hormone-Gland)
- Family Practice
- General Practice
- General Surgery
- Geriatrics (Treatment of Aged)
- Gynecology (Women's Reproductive Healthcare)
- Internal Medicine (Internal Organs)

- Laboratory
- Nephrology (Kidney Disease)
- Neurological Surgery (Nervous System and Brain Surgery)
- Neurology (Nervous System)
- Nurse Practitioner
- OB/GYN (Women's Reproductive Health and Child Bearing)
- Obstetric (Child Bearing)
- Oncology (Cancer)
- Ophthalmology (Eye Specialist)
- Optometry (Eye/Vision Care)
- Oral Surgery (Mouth Surgery-Dentists)
- Orthopedic Surgery (Bone Surgery)
- Otolaryngology (Ear, Nose and Throat)
- Pathology (Examination of Body Tissue and Fluids)
- Pediatrics (Treatment of Children)
- Plastic Surgery (Reconstruction of Tissue and Bone)
- Podiatry (Feet)
- Proctology (Treatment of the Rectum)
- Pulmonary Disease (Lung Specialist)
- Radiology (X-Ray)
- Rheumatology (Joints and Muscles)
- Thoracic Surgery (Chest)
- Urology (Bladder, Kidney and Urinary Tract)

Printed copies of the provider directories are available from your benefits office or, if you are a retiree, survivor or COBRA participant, from EIP.

BlueCard Program

When you need medical care outside South Carolina, through the BlueCard Program and BlueCross BlueShield provider networks, you have access to doctors and hospitals throughout the United States and around the world. Please refer to the mental health and substance abuse section beginning on page 43 for information on how those benefits are handled outside South Carolina.

Inside the U.S.

With the BlueCard Program you can choose the doctors and hospitals that best suit you and your family. Follow these steps for health coverage when you are away from home within the United States:

1. Always carry your current SHP identification card.
2. In an emergency, go directly to the nearest hospital.
3. To find the names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard *Access* at 800-810-2583.
4. Call Medi-Call for precertification or prior authorization, if necessary. (The toll-free number is listed on your SHP ID card.)
5. When you arrive at the participating doctor's office or hospital, show your SHP ID card. As a BlueCard Program member, the doctor will recognize the logo, which will ensure that you will get the highest level of benefits with no balance billing.

After you receive care, you should not have to complete any claim forms, nor should you have to pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). You will be mailed a complete explanation of benefits.

Outside the U.S. Outside the United States, follow the same process as in the United States, with these exceptions:

- In most cases, you should not need to pay up front for inpatient care at BlueCard Worldwide hospitals. You are responsible for the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). The hospital should submit your claim.

- You pay the doctor or hospital for inpatient care at non-BlueCard worldwide hospitals, outpatient hospital care and other medical services. You will then complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available from your benefits administrator or through www.southcarolinablues.com.

Outside the United States, you can call 800-810-2583 or call collect at 804-673-1177, 24 hours a day, seven days a week, for information on doctors, hospitals and other health care professionals or to receive medical assistance services around the world. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization, if necessary.

A Note to Retirees Remember that the Medicare Supplemental Plan follows Medicare rules. Since Medicare does not provide worldwide coverage, BlueCard Worldwide coverage **is not** available to the Medicare Supplemental Plan subscribers.

Prescription Drug and Mental Health/Substance Abuse Provider Networks

Since there is no SHP coverage out-of-network for prescription drugs or mental health/subsance abuse care, it is important that you find a participating network provider for these services. These provider networks are listed on Web sites sponsored by Medco, the prescription drug benefit administrator, and APS Healthcare, Inc., the mental health and substance abuse administrator. These sites are accessible through the EIP Web site, www.eip.sc.gov. Choose your category and then select "Online Directories." You will see a list of links to provider directories. You can also go there directly:

- To see the list of network pharmacies, go to: www.medco.com

- Mental health and substance abuse providers include: psychiatrists, clinical psychologists, masters-level therapists and nurse practitioners. To see the list, go to the APS Healthcare, Inc. Web site at www.apshealthcare.com. Choose "Employer Clients" in the top menu bar then "South Carolina" from the drop-down menu. The access code is "statesc." Or call APS Healthcare toll-

free at 800-221-8699 to be directed to a network provider and to receive the required pre-certification.

For more information on your drug benefits, see page 39, and for more information on your mental health and substance abuse benefits, see page 43.

Hard copies of the provider directories are available from your benefits office or, if you are a retiree, survivor or COBRA participant, from EIP.

Out-of-Network Benefits

In the SHP, you can use providers who are not part of the plan network and still receive some coverage for medical care. When you do this, you will pay a larger portion of the bill yourself, and you also will fill out the claims forms. **Remember, there is no coverage for prescription drugs or mental health and substance abuse care if you use a non-network provider or fail to pre-certify services.**

Balance Billing

If you use a non-network provider, you may be subject to "balance billing." SHP network providers are prohibited from billing you for covered services except for the allowed copays, coinsurance, and deductibles. However, a non-network provider may choose to bill you for more than the SHP's maximum allowance for the covered service. The difference between what the non-network provider charges and the SHP allowed charge is called the "balance bill."

Out-of-Network Differential

In addition to balance billing, if you choose a provider that does not participate in the SHP or BlueCard network, you will pay 40 percent, instead of the usual 20 percent, in coinsurance. Prescription drug and mental health/substance abuse services are not covered, unless you use a network provider.

This example shows how you save money using a network provider:

You have employee-only coverage under the SHP. You have received no other medical care during the year, so you have not met your deductible. The non-network provider charges $5,000 for the covered services you receive, but the SHP maximum allowance is $4,000.

Standard Plan

For an individual covered under the **Standard Plan**, using a ***network*** provider: You pay the network provider $350, which is applied to your Plan deductible. The Plan then pays the balance of the SHP maximum allowance ($3,650) at 80 percent coinsurance, or $2,920. The remaining $730 in coinsurance is your responsibility, and it is applied towards your $2,000 coinsurance maximum.

Your Standard Plan out-of-pocket expenses for the services of a network provider: **$1,080.**

If you had used a ***non-network*** provider for the same services: You pay the $350 Standard Plan deductible. The Plan then pays the balance of the SHP

maximum allowance ($3,650) at 60 percent coinsurance, or $2,190. The remaining $1,460 in coinsurance, as well as the $1,000 "balance billing" from the non-network provider, are your responsibility. There is a $4,000 coinsurance maximum when you use a non-network provider under the Standard Plan, so the $1,460 is applied towards your coinsurance maximum.

Your Standard Plan out-of-pocket expenses for the services of a non-network provider: **$2,810.**

Standard Plan subscribers also pay any applicable per-occurrence or per-visit deductibles (which would not apply toward meeting your deductible) both in-network and out-of-network. They are not included in this example.

Savings Plan
For an individual covered under the **Savings Plan**, using a ***network*** provider: You pay the provider $3,000, which is applied to your Plan deductible. The Plan then pays the balance of the SHP maximum allowance ($1,000) at 80 percent coinsurance, or $800. The remaining $200 in coinsurance is your responsibility, and is applied towards your $2,000 coinsurance maximum.

Your Savings Plan out-of-pocket expenses for the services of a network provider: **$3,200.**

If you had used a ***non-network*** provider for the same services: You pay the $3,000 Savings Plan deductible. The Plan then pays the balance of the SHP maximum allowance ($1,000) at 60 percent coinsurance, or $600. The remaining $400 in coinsurance, as well as the $1,000 "balance billing" from the non-network provider, is your responsibility. Because there is no limit on the amount of coinsurance you pay for non-network providers, the Plan will never pay 100 percent of your covered medical expenses. There is no coinsurance maximum when you use a non-network provider under the Savings Plan, so the $400 is not applied towards your coinsurance maximum.

Your Savings Plan out-of-pocket expenses for the services of a non-network provider: **$4,400.**

Filing SHP Claims

If you received services from a physician or hospital that participates in a SHP network, you do not have to file claims. Your doctor or hospital will file for you.

However, if you did not use a network physician or hospital, or have a claim for a non-network service, you may have to file the claim yourself. You can get claim forms from your benefits office, EIP or BlueCross BlueShield. Claim forms also are available on the EIP Web site. Go to www.eip.sc.gov, then choose your category and select "Forms."

To file a claim you need to:

- Complete the front side of the claim form
- Attach your itemized bills, which must show: the amount charged; the patient's name; the date and place of service; the diagnosis, if applicable; and the provider's federal tax identification number, if available
- File claims within 90 days of the date you receive services or as soon as reasonably possible

BlueCross BlueShield must receive medical claims by the end of the calendar year after the year in which expenses are incurred. Otherwise, claims cannot be paid.

Complete a separate claim form for each individual who has received care, and mail the form to BlueCross BlueShield at:

State Group Processing Unit
BlueCross BlueShield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605.

In most cases, If you obtain medical services while outside South Carolina and the United States at a BlueCard doctor or hospital, you should not need to pay up front for inpatient care. You are responsible for the usual out-of-pocket expenses (deductible, copayment, coinsurance and non-covered services). The doctor or hospital should submit your claim.

At non-BlueCard doctors and hospitals, you pay the doctor or hospital for inpatient care, outpatient hospital care and other medical services. You must then complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available from your benefits administrator or online through www.southcarolinablues.com.

How to file a Manual Prescription Drug Claim

If you fail to show your SHP ID card, or if you incur prescription drug expenses while traveling outside the United States, you will have to pay full retail price for your prescription and then file a claim with Medco for reimbursement. Reim-

bursement will be limited to the Plan's allowable charge, less the copayment. You must file your claim with Medco within one year of the date of service.

Remember that benefits are NOT payable if you use a non-participating pharmacy in the United States. However, if you incur prescription drug expenses at a non-participating pharmacy while traveling outside the United States, you will be able to file a claim with Medco. Reimbursement of your expenses will be limited to the Plan's allowable charge, less the copayment.

To file a claim for prescription drug expenses incurred at a participating pharmacy or outside the United States, call Medco's Member Services at 800-711-3450.

Managing Your Medical Care

Medi-Call

Certain benefits under the State Health Plan require approval before you receive them. A phone call gets things started. While your healthcare provider **may** make the call for you, it is your responsibility to call for authorization.

800-925-9724 (South Carolina, nationwide, Canada)
803-699-3337 (Greater Columbia area)

Medi-Call is the SHP's utilization review program. Medi-Call makes sure you and your covered family members receive appropriate medical care in the most beneficial, cost-effective manner. **Participation in Medi-Call is mandatory whether you are enrolled in the Standard Plan or in the Savings Plan.** You must contact Medi-Call at least 48 hours or two working days, whichever is greater, before receiving the following medical services at any medical facility in the United States or Canada:

- You need inpatient care in a hospital[1]
- Your precertified outpatient services result in a hospital admission (you must call again for the hospital admission)
- You need outpatient surgery for septoplasty, hysterectomy or sclerotherapy
- You need a MRA, MRI or CT Scan
- You will be receiving chemotherapy or radiation therapy
- You need a second opinion
- You are admitted to a hospital in an emergency situation (your admission must be reported within 48 hours or the next working day) [1]
- You are pregnant (you must call within the first three months of your pregnancy)
- You have an emergency admission during pregnancy[2]
- You deliver your baby[2]
- Your newborn has complications at birth
- You are admitted to a skilled nursing facility, use home health care, hospice care or an alternative treatment program or need durable medical equipment
- You or your covered spouse decides to undergo any In Vitro Fertilization (IVF) procedure
- You or your covered family member needs to be evaluated for a transplant
- You need inpatient rehabilitative services and related outpatient physical, speech and occupational therapies
- Any procedure that may potentially be considered cosmetic in nature must be received in writing by Medi-Call seven days before surgery (i.e., blepharoplasty, reduction mammoplasty, TMJ or other jaw surgery)

[1]*For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for precertification before admission, or within 24 hours of an emergency admission.*

[2]*Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by completing and filing an NOE, within 31 days of birth, for benefits to be payable.*

Medi-Call approval does not guarantee payment of benefits. Claim payments are still subject to the rules of the Plan.

Are There Penalties for not Calling?

Yes. If you do not call Medi-Call in the required situations, you will be required to pay a $200 penalty for each hospital or skilled nursing facility admission. In addition, the coinsurance maximum will not apply. In other words, you will continue to pay your coinsurance, no matter how much you pay out-of-pocket.

Maternity Management

If you are a mother-to-be, you **must** participate in the Maternity Management Program administered by Medi-Call. Prenatal care is a good way to ensure your health and your baby's health. You must call Medi-Call within the first trimester (three months) of your pregnancy to precertify your pregnancy. If you do not call Medi-Call within the first trimester, or if you refuse to participate in the Maternity Management Program, you will pay a $200 penalty for each maternity-related hospital or skilled nursing facility admission. This penalty will be in addition to the Medi-Call precertification penalty, and the $2,000 coinsurance maximum will not apply.

You are automatically enrolled in the program when you call Medi-Call to precertify your pregnancy. As a participant in the program, you will receive a letter from Medi-Call welcoming you to the program and a packet of important information to refer to during your pregnancy.

A case management nurse will complete a Maternity Health Assessment form when you enroll. This form is used to identify potential high-risk factors during your first trimester. If high-risk factors are identified, you will be scheduled for follow-up calls. If no risks are identified, you should call with any changes in your condition. Otherwise, you will be sent a reminder card with benefit information during your third trimester.

Also, you can call Medi-Call anytime you have questions. A maternity case management nurse will be there to help you throughout your pregnancy. **Remember, there are penalties for not participating in this program. See Medi-Call on page 26 for more details.**

Managing For Tomorrow®

If you have a chronic condition, such as diabetes, heart disease or asthma, you know that taking care of yourself can be challenging. It's a 24-hours-a-day, seven-days-a-week effort. Being a good manager of your health care starts with understanding your condition and your doctor's plan for your care.

Managing for Tomorrow® can help. It is available to active employees, non-Medicare retirees, spouses and dependents covered by the SHP. You may receive a letter or phone call about this unique health management program sponsored by BlueCross BlueShield of South Carolina in cooperation with Prevention Partners.

The program is designed to help you learn more about your condition and ways to improve your health. It is voluntary and offered at no cost. You will not be asked to purchase anything, your benefits will not be affected, and your premiums or copayments will not increase when you participate in Managing for Tomorrow®.

The program starts with an invitation to participate in a confidential survey. The survey helps determine which health education materials are right for you. You will receive a special Personal Identification Number (PIN). This PIN will allow you to complete the survey by calling an automated phone line or by logging on to a secure Web site. Paper surveys also are available.

Everyone who receives an invitation is encouraged to take part in the Managing for Tomorrow® program. If you think you qualify but have not been invited, call the BlueCross Disease Management department at 800-925-9724.

Complex Care Management

Facing a serious illness or injury often can be overwhelming, confusing and frustrating. You may not know where to find support or information to help you cope with your illness, and you may not know what treatment options are available.

Complex Care Management can help. Available to active employees, spouses and dependents covered by the Standard Plan and the Savings Plan, this program lets you make informed decisions about your healthcare when you are seriously ill or injured.

Offered by BlueCross BlueShield of South Carolina and Franklin Health, Inc., the program provides you information and support through a local care coordinator who is a registered nurse. This coordinator acts as an advocate for you and your family. He can help you identify treatment options, locate supplies and equipment recommended by your doctor, coordinate care with your doctor and the SHP, and research the availability of special transportation and lodging for out-of-town treatments.

Participation in the program is voluntary and is offered at no charge. You can leave the program at any time, for any reason. Your benefits will not be affected by your participation in the program.

Here is how the program works: BlueCross BlueShield will refer you to Franklin Health if the program may be of benefit to you. You will receive a letter explaining the program and a Franklin Health representative will contact you. A care coordinator in your area will visit you to discuss ways he can help you and will ask permission to contact your doctor to offer assistance.

The Franklin Health team, comprised of specially trained nurses and doctors, will review your medical information and treatment plan. (Please note that your medical history and information will always be kept confidential among your caregivers and the Franklin Health team.)

Your local care coordinator will be your main program contact. You and your doctor, however, will always make the final decision about your treatment.

Everyone who is referred to Franklin Health is encouraged to take part in the Complex Care Management Program. By working closely with your doctor and using the resources available in your community, the program can help you through a difficult time in your life. If you would like more information on the Complex Care Management Program, call 800-868-2500, ext. 42648.

State Health Plan Benefits

The Standard Plan and the Savings Plan pay benefits for medically necessary treatments of illnesses or injuries. The information in this chapter does not constitute your health plan or insurance policy. It is only a general description of the plan. The *Plan of Benefits* document contains a complete description of the benefits. Its terms and conditions govern all health benefits offered by the state. Contact your benefits administrator or EIP for more information. Some services and treatments require precertification by Medi-Call or APS Healthcare. Be sure to read page 26 and page 43 for details on precertification.

Ambulance

Ambulance service is covered when used locally to or from a hospital outpatient department providing necessary service in connection with an injury or a medical emergency and to or from the nearest hospital providing necessary service in connection with inpatient care. No benefits are payable for ambulance service used for routine, non-emergency transport, including, but not limited to, transportation to a facility for scheduled medical or surgical treatments.

Doctor Visits

Charges for treatments or consultations for an injury or illness are covered as long as they are medically necessary. For mental health and substance abuse services to be covered, you must use a participating provider, and all mental health and substance abuse services must be pre-authorized.

Standard Plan

Each time you receive services in a professional provider's office there is a per-visit deductible of $10, which does not apply to your annual deductible or out-of-pocket maximum. This deductible is waived for routine pap tests, routine mammograms and well child care visits.

Savings Plan

There are no per-visit deductibles under the Savings Plan.

Diabetic Supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. Since most insulin is brand name, it will require a $25 copayment for each supply of up to 31 days. Diabetic supplies, including syringes, lancets and test strips, will be covered at participating pharmacies for a $10 copayment, per item, for each supply of up to 31 days. Durable medical equipment, which includes insulin and diabetic supplies, continues to be payable under the SHP. Claims for durable medical equipment should be filed with BlueCross BlueShield of South Carolina.

Contraceptives

For employees and covered spouses, routine contraceptive prescriptions, including birth control pills and injectibles (Depo-Provera and Lunelle) that are filled at a participating pharmacy are covered as prescription drug benefits. They are subject to the same terms as other prescription drugs. Birth control implants and injectibles that are given in a doctor's office are covered as a medical expense.

Organ Transplants

SHP transplant contracting arrangements include the BlueCross BlueShield Association (BCBSA) national transplant network, Blue Quality Centers for Transplants (BQCT). All BQCT facilities meet specific criteria that consider provider qualifications, programs and patient outcomes.

All transplant services must be approved by Medi-Call (see page 26). You must call Medi-Call even before you or a covered family member is evaluated for a transplant.

Through the network, Blue Quality Centers for Transplants, those covered by the SHP have access to the leading organ transplant facilities in the nation, in addition to the savings the network brings to the Plan. Contracts are still in effect with several in-state providers for transplant services so that individuals insured by the Plan may continue to use those facilities. If you receive transplant services at one of these network facilities, you will not have to worry about balance billing. You will be responsible only for your deductible, coinsurance and any charges not covered by the Plan. In addition, these facilities will file all claims for you.

Transplant services at non-participating facilities will be covered by the Plan. However, the SHP will pay only the SHP allowed charges for transplants performed at non-network facilities. If you do **not** receive your transplant services at a network facility, you may pay substantially more.

In addition to the deductible and coinsurance, subscribers using non-network facilities are responsible for any amount over the allowable charges and will pay an additional 20 percent in coinsurance, totaling 40 percent, because they used out-of-network providers. (There is no out-of-network coinsurance maximum for **Savings Plan** subscribers.)

Costs for transplant care can vary by hundreds of thousands of dollars. If you choose care outside the network, you cannot be assured that your costs will not exceed those allowed by the Plan. Call Medi-Call for more information.

Extended Role Nurse

Expenses for services received from a licensed, independent extended role nurse are covered, even if these services are not performed under the direction of a doctor. An extended role nurse is a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or a clinical nurse specialist. All services received must be within the scope of the nurse's license.

Infertility

The Plan will pay for diagnosis and treatment of infertility under these terms and conditions: maximum lifetime benefits are $15,000 per person; a maximum of three cycles of gamete or zygote intrafallopian transfer (GIFT or ZIFT), or In Vitro Fertilization (IVF), are allowed; benefits are payable at 70 percent of allowable charges. Your share of the expenses does not count toward your coinsurance maximum. All IVF procedures must be approved by Medi-Call.

The Plan will not provide infertility benefits to subscribers who have had a tubal ligation. Prescription drugs for treatment of infertility are subject to a 30 percent coinsurance payment under both the Savings Plan and the Standard Plan. This

does not apply to the $2,500, per person, out-of-pocket maximum under the Standard Plan. It does apply to the Savings Plan deductible. The 70 percent plan payment for prescription drugs for infertility treatments does apply to both plans' $15,000 maximum lifetime benefit for infertility treatments. Call Medco's Member Services at 800-711-3450 for more information.

Inpatient Hospital Services

Inpatient hospital care, including room and board, is covered. In addition to normal visits by your physician while you are in the hospital, you are covered for one consultation per consulting physician for each inpatient hospital stay.

Outpatient Services

Outpatient laboratory, X-ray, emergency room, radiation therapy, pathology services, outpatient surgery, diagnostic tests and medical supplies are covered. (If the diagnosis is psychiatric, only services provided at APS network facilities are covered.) Some medical laboratories and radiology services are not network providers. If you use the services of a provider that is not in network, the provider may charge you more than the allowable charge, and you will be balance billed.

Standard Plan

The per-occurrence deductible for each emergency room visit is $125. This deductible is waived if you are admitted to the hospital. The deductible for each outpatient hospital service is $75. This deductible is waived for dialysis, routine mammograms, routine pap smears, clinic visits (an office visit at an outpatient facility), emergency room, oncology, electro-convulsive therapy, psychiatric medication management and physical therapy visit. Outpatient facility services for psychiatric diagnoses must be provided at an APS Network facility to be covered, and clinic visits for mental health services are not covered.

Savings Plan

There are no per-occurrence deductibles under the Savings Plan.

Pregnancy and Pediatric Care

Pregnancy benefits are provided to a female employee or retiree and the dependent wife of a male employee or retiree. Dependent children do not have maternity benefits. Maternity benefits include necessary prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. If you are pregnant, you must call Medi-call within the first three months of your pregnancy to enroll in the Maternity Management Program. See page 27 for more information.

Under federal law, group health plans cannot restrict benefits for the length of any hospital stay in connection with childbirth for the mother or the newborn to less than 48 hours following normal, vaginal delivery or less than 96 hours following a cesarean section or require a provider to obtain authorization from the plan for prescribing a length of stay within the above periods. The law generally does not prohibit an attending provider in consultation with the mother from discharging earlier than 48 or 96 hours, as applicable.

Prescription Drugs

Prescription drugs, including insulin, are covered subject to Plan exclusions and limitations, provided you use a participating pharmacy. Drugs in FDA phase I, II

or III testing are not covered. Prescription medications associated with infertility treatments have a different coinsurance rate. Please refer to page 31 for more information.

Reconstructive Surgery after Mastectomy

If you have a mastectomy and elect to have breast reconstruction in connection with the mastectomy, the Plan will cover:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance and
- Prostheses and physical complications in all stages of mastectomy, including lymphedema

Remember that these services apply only in post-mastectomy cases and that all services must be approved by Medi-Call.

Rehabilitation

The Plan provides limited rehabilitation benefits. They are subject to the terms and conditions of the Plan, including:

- Precertification is required for any inpatient admission and outpatient rehabilitation therapy that occurs after an inpatient admission for rehabilitation therapy
- There is reasonable expectation that sufficient function can be restored to enable the patient to live outside the hospital setting
- Significant improvement continues to be shown

The Plan does not pay for:

- Long-term rehabilitation after the acute phase of treatment for injury or illness
- Vocational rehabilitation
- Pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant)
- Behavior therapy, including speech therapy associated with behavior
- Cognitive retraining
- Community re-entry programs

Second Opinion

If Medi-Call advises you to seek a second opinion before a medical procedure, the Plan will pay 100 percent of the cost for that opinion. These procedures include surgery as well as treatment (including hospitalization). If APS Healthcare advises you to seek a second opinion before receiving treatment for mental health or substance abuse services, the Plan will pay 100 percent of the cost for that opinion.

Surgery

Physician charges for medically necessary inpatient surgery, outpatient surgery and use of surgical facilities are covered.

Skilled Nursing Facility

The Plan will pay limited benefits for room and board in a skilled nursing facility for up to 60 days or $6,000 based on a per day rate, whichever is less. Physician visits are limited to one per day. These services require authorization by Medi-Call.

Hospice Care

The Plan will pay benefits for care you receive from a hospice for patients who are terminally ill. The maximum benefit is $6,000 per covered person, including a bereavement counseling maximum of $200. These services require authorization by Medi-Call.

Alternative Treatment Plans

An alternative treatment plan is an individual treatment program to permit treatment in a cost-effective and less intensive manner than is ordinarily required. It requires the approval of the treating physician, BlueCross BlueShield, Medi-Call and the patient. Services and supplies that are medically necessary because of the approved alternative treatment plan will be covered.

The Plan will pay for extended care as an alternative to hospital care only if it is approved by Medi-Call.

Home Healthcare

The Plan covers home healthcare performed by a private or public agency. You cannot receive home healthcare and hospital or skilled nursing care benefits at the same time. Benefits are limited to $5,000 or 100 visits per year, whichever is less. These services require authorization by Medi-Call.

Other Covered Expenses

These expenses are covered if they are determined to be medically necessary:

- Blood and blood plasma
- Nursing services
- Durable medical equipment
- Prosthetic appliances
- Oxygen and rental of oxygen equipment
- Orthopedic braces, crutches, lifts attached to braces and orthopedic shoes
- Dental treatments or surgery to repair damage from an accident, for up to one year from the date of the accident
- Dental surgery for bony, impacted teeth

Preventive Benefits

The SHP has benefits and programs that can help make it easier for you and your family to stay healthy. These benefits provide you with resources to help you feel better and enjoy a better quality of life. By helping to prevent potentially expensive health problems and hospital admissions, these benefits help control medical claims costs, saving you and the Plan money.

Early Detection Benefits

Preventive Worksite Screening

This comprehensive health screening, coordinated by Prevention Partners, measures cholesterol levels, blood pressure, triglyceride levels, kidney function and red and white blood cell counts. These measurements indicate if an employee is at risk for developing hypertension, diabetes and anemia. This benefit is available for $15 to subscribers whose primary coverage is the Standard Plan, the Savings Plan, Companion HMO, CIGNA HMO or MUSC Options.

The cost of the Preventive Worksite Screening benefit does not contribute toward your annual deductible or out-of-pocket maximum.

Who can Participate?

All eligible employees of worksites with state coverage, including state agencies, public school districts, counties and municipalities and local subdivisions may participate. Retiree subscribers are eligible if the State Health Plan is their primary insurance coverage. Those covered by Medicare are not eligible.

For more information on Prevention Partners, contact your benefits office, your Prevention Partners coordinator or call 803-737-3820 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area). You also can go to the EIP Web site at www.eip.sc.gov.

Mammography Program

Routine, four-view mammograms are covered at 100 percent as long as you use a participating facility and meet eligibility requirements. You do not need a doctor's referral for a routine mammogram under the Plan.

- If you are age 35 through 39, one baseline mammogram will be covered during those years.
- If you are age 40 through 49, one routine mammogram every other year will be covered.
- If you are age 50 through 74, one routine mammogram a year will be covered.

Charges for routine mammograms performed at non-participating facilities are not covered, with the exception of procedures performed outside South Carolina. However, non-network providers are free to charge you any price for their services, so you may pay more.

For women, age 40 and older, covered through the retiree group and enrolled in Medicare, Medicare pays for one routine mammogram every year. The SHP is primary for women covered through the active group, regardless of Medicare eligibility.

Pap Test Program

The Plan will pay a benefit each year for a Pap test if you are a covered female age 18 through 65. You can receive this benefit whether or not the Pap test is for routine or diagnostic purposes. The benefit does not include the doctor's visit.

Well Child Care Benefits

What is Well Child Care?

The Standard Plan and the Savings Plan provide coverage for routine checkups and immunizations for children through age 12. Well Child Care benefits are designed to promote good health and aid in the early detection and prevention of illness among children.

Who is Eligible?

Covered dependent children from birth through age 12 are eligible for Well Child Care benefits.

How Does it Work?

This benefit covers regular doctor visits and timely immunizations. When services are received from a doctor in the SHP Physician Network, benefits will be paid at 100 percent without any deductible or coinsurance. **Benefits will not be paid for services from non-network providers.** Some services may not be considered part of the well child visit. For example, if during a well child visit a fever and sore throat were discovered, the lab work to verify the diagnosis would not be part of the routine visit. These charges would be subject to deductible and coinsurance, as would any other medical expense.

Checkups

This is the schedule of regular checkups for which the Plan pays 100 percent when a network doctor provides the services:

- less than 1 year old—five visits
- 1 year—three visits
- 2 through 5 years—one visit per year
- 6 through 8 years—one visit during three-year period
- 9 through 12 years—one visit during four-year period

Immunizations When you use a network doctor, the Plan pays 100 percent of the cost for your children's immunizations at the appropriate ages. This is the recommended schedule:

Disease	Recommended Immunization Schedule
Hepatitis B	birth-2 months 1-4 months 6-18 months 11-12 years if not had before
Polio	2 months 4 months 6-18 months 4-6 years
Diphtheria-Tetanus-Pertussis (DTaP)	2 months 4 months 6 months 15-18 months 4-6 years 11-12 years if none in last five years
Haemophilus (Hib)	2 months 4 months 6 months 12-15 months
Pneumococcal Conjugate (PCV7)	2 months 4 months 6 months 12-15 months
Measles-Mumps-Rubella (MMR)	12-15 months four-six years 11-12 years if not had second dose before
Chickenpox	12-18 months 11-12 years if not had disease or vaccine before

If your children have not been immunized at the recommended times, please contact your pediatrician or call Medi-Call for instructions on how to get your children properly immunized.

Wellness Benefits for Savings Plan Participants

As a participant in the Savings Plan, you are encouraged to take greater responsibility for your health. To make that easier, your plan offers more preventive benefits at no cost to you. They include:

- A yearly flu shot for each eligible participant
- Access to the 24-hour Health at Home® Nurseline, through which registered nurses provide personal, immediate assistance to subscribers. The toll-free number is listed on the back of your Health Plan ID card and on the cover of the self-care handbook.
- A copy of the 416-page, full-color self-care handbook, *Health at Home®—Your Complete Guide to Symptoms, Solutions & Self-Care.*

Children age 12 and younger receive the Well Child Care benefits that are also offered to those enrolled in the Standard Plan. Savings Plan participants age 13 and older may receive from a network provider an annual physical that includes:

- A preventive, comprehensive examination
- A complete urinalysis
- An EKG
- A fecal occult blood test
- A general health laboratory panel "blood work"
- A lipid panel every five years
- A pap test

Prevention Partners Programs

Prevention Partners, coordinated by the Employee Insurance Program, is designed to help you and your family lead healthier lives. The mission of Prevention Partners is to provide activities, programs and services for disease prevention, early detection of disease, demand management and health promotion. To encourage health promotion, disease prevention and detection of disease, Prevention Partners conducts these programs:

- Preventive Worksite Screening benefit
- Spring Wellness Walk
- Lifestyle change workshops on lowering risk factors, weight loss and exercise
- Chronic disease management workshops on asthma, diabetes and healthy heart
- Worksite program consultation
- Volunteer Worksite Prevention Partners coordinator network and conferences
- Prevention Partners training workshops

Natural Blue

"Natural Blue" is a discount program available to SHP subscribers. A part of BlueCross BlueShield of South Carolina, it offers holistic healthcare choices and information. The program has a network of licensed acupuncturists, massage therapists and fitness clubs that may be used at lower fees, often as much as a 25-percent discount. "Natural Blue" also offers discounts on laser vision correction and health products, such as vitamins, herbal supplements, books and tapes. For more on "Natural Blue," log on to the Web site at www.healthyroads.com.

Prescription Drug Program

Prescription Drugs – 800-711-3450

Prescription drugs are a major benefit to you and a major part of the cost of our self-insured health plan. Using generic drugs saves you and the Plan money. You also can save money, and receive the same FDA-approved drugs, when you refill prescriptions through Medco by Mail, the mail-order prescription service. Remember, benefits are paid only for prescriptions filled at network pharmacies or through the mail service. Prescription drugs, including insulin, are covered subject to Plan exclusions and limitations, provided you use a participating pharmacy. Drugs in FDA phase I, II or III testing are not covered. Prescription medications associated with infertility treatments have a different coinsurance rate. Please refer to page 31 for more information.

Standard Plan

The prescription drug benefit, administered by Medco, is easy and convenient to use. With this program, you show your SHP identification (ID) card when you purchase your prescriptions from a participating retail pharmacy and pay a copayment of $10 for generic, $25 for preferred brand or $40 for non-preferred brand drugs for up to a 31-day supply. If the price of your prescription is less than the copayment, you pay the lesser amount. **Prescription drug benefits are payable without an annual deductible.** There are no claims to file. The prescription drug benefits are the same for the Standard Plan and the Medicare Supplemental Plan.

The prescription drug benefit has a separate annual copayment maximum of $2,500 per person. This means that after you spend $2,500 in prescription drug copayments, the Plan will cover your allowable prescription drug expenses, at no cost to you, for the remainder of the year.

Drug expenses do not count toward your medical annual deductible, coinsurance maximum or your lifetime maximum benefit.

Savings Plan

With this program, you show your SHP identification (ID) card when you purchase your prescriptions from a participating retail pharmacy and pay the full allowable cost of your prescription drugs when you purchase them. There is no copayment.

This cost is transmitted electronically to BlueCross BlueShield of South Carolina. If you have not met your annual deductible, the full allowable cost of the drug will be credited to it. If you have met your deductible, you will be reimbursed for 80 percent of the allowable cost of the drug. The remaining 20 percent of the drug will be credited to your coinsurance maximum.

Generic Drugs

Under both plans, your prescription drug choices are divided into three categories: generic, preferred brand and non-preferred brand.

Generic medications may differ in color, size or shape, but the FDA requires that the active ingredients have the same strength, purity and quality as the brand-name alternatives. Prescriptions filled with generic drugs often have lower allowable cost, under the Savings Plan, and lower copayments, under the Standard Plan. Therefore, you get the same health benefits for less.

"Pay-the-Difference" Policy

Under the State Health Plan, there is a "pay-the-difference" policy. This means if you purchase a brand-name drug when there is an equivalent generic drug available, the benefit will be limited to that for the generic drug. This policy will apply, even if the doctor prescribes the medication as "Dispense As Written" or "Do Not Substitute".

Under the **Standard Plan,** if you purchase a brand-name drug over a generic, you will be charged the generic copayment, PLUS the difference in price between the brand-name and the generic drug. If this amount is less than the preferred or non-preferred brand copayment, you will pay the applicable brand copayment. Only the copayment for the generic drug will apply toward your copayment maximum.

Under the **Savings Plan**, if you purchase a brand-name drug over a generic, only the allowable cost for the generic drug will apply toward your deductible. After you have met your deductible, only the allowable cost for the generic drug will apply toward your coinsurance maximum.

If you are taking a brand-name drug, you may wish to discuss with your doctor the possibility of using a generic drug, if one is available. If appropriate, the doctor may note on the prescription that substitution is permitted.

Preferred Brand Drugs

These are medications that Medco's Pharmacy and Therapeutics Committee has determined to be safe, effective and available at a lower cost than non-preferred brand drugs. A list of preferred brand medications is available online at www.medco.com. You may reach the Medco Web site through the EIP Web site by clicking on the "Insurance Managers" link.

Non-Preferred Brand Drugs

These medications are not on the Preferred Brand list and carry a higher copayment or higher price. All medications that appear on the non-preferred brand list have an effective alternate option either as a generic or a preferred-brand drug.

Prior Authorization

Some medications will be covered by the Plan only if they are prescribed for certain uses. These drugs must be authorized in advance, or they will not be covered under the Plan. If the prescribed medication must be pre-authorized, you or your pharmacist may begin the review process by contacting Medco at 800-711-3450.

Retail Pharmacy

You must use a participating pharmacy, and you must show your SHP ID card when purchasing medications. The SHP participates in the Select Rx Network, Medco's pharmacy network. Most major pharmacy chains and independent pharmacies participate in this network. A list of participating pharmacies is available online through the EIP Web site, www.eip.sc.gov (Choose your category, then select "Online Directories") or at www.medco.com.

Mail Order Prescription Service

The Standard Plan and the Savings Plan offer mail-order service for 90-day supplies of prescriptions. By using this service, you receive a discount on the same FDA-approved prescription drugs that you would buy at a retail pharmacy.

Mail order is an ideal option for anyone with a recurring prescription, such as birth control medication, or a chronic condition, such as asthma, high cholesterol or high blood pressure.

Standard Plan
Generic drug copayments are $25, preferred-brand drug copayments are $62, and non-preferred brand drug copayments are $100 for up to a 90-day supply.

Savings Plan
You pay the full allowable cost when you order prescription drugs through the mail. However, that cost for a 90-day supply will typically be less than you would pay at a retail pharmacy.

How to Order Drugs by Mail

This is how the mail-order service works:

- Ask your physician to write your prescription for a single 31-day supply and for a 90-day supply with refills.
- Fill your prescription for a 31-day supply at a participating retail pharmacy.
- Complete a mail-order prescription form and mail it to Medco. (Forms are available through the EIP Web site, www.eip.sc.gov under "Forms" or on Medco's Web site: www.medco.com.)
- Your order will be processed and sent to your home, typically within 10-14 business days. Meanwhile, use your prescription from your retail pharmacy.

Once the initial prescription has been entered and filled, you may order refills online or by phone using Medco's toll-free number: 800-711-3450.

If you plan to order a drug by mail, you may wish to check with your doctor or with Medco to make sure a 90-day supply of that specific drug may be sold. In some cases, drugs are limited to less than a 90-day supply because of state law or packaging limitations. If you have questions, call Medco at 800-711-3450.

If you want to save money by ordering a 90-day supply by mail, be sure to ask your doctor to write a prescription for a **90-day supply with refills**. Under the **Standard Plan,** prescriptions written for a 31-day supply with refills will be filled for a 31-day supply, and you will be charged the same copayment that is charged for a 90-day supply. Under the **Savings Plan**, you can buy less than a 90-day supply.

Coordination of Benefits

The State Health Plan coordinates prescription drug benefits, as well as medical benefits. This ensures that if you are covered by more than one health plan, both plans pay their share of the cost of your care. See page 16 for more information.

Exclusions

Some prescription drugs are not covered under the Plan. See page 45 for more information.

Prior Authorization

Some drugs will be covered by the Plan only if they are prescribed for certain uses and therefore must receive prior authorization. If the prescribed medication must be pre-authorized, you or your pharmacist may begin the review process by contacting Medco at 800-711-3450.

Behavioral Health Benefits

Mental Health and Substance Abuse – 800-221-8699

APS Healthcare, Inc., is the administrator for the mental health and substance abuse benefit. Claims for mental health and substance abuse are subject to the same deductibles, coinsurance and out-of-pocket maximums as medical claims. There are no caps on the number of provider visits allowed, and there is not a separate annual and lifetime maximum for substance abuse benefits.

Here is how the SHP mental health and substance abuse program works:

- When you need care, call APS Healthcare at 800-221-8699 toll-free to receive pre-authorization and to be directed to a national network of providers. The provider network is open, which means that any eligible provider can participate in the network. **If you do not call APS Healthcare or if you choose to use a non-participating provider, no benefits will be payable.**

- To review the network of participating providers, log on to the EIP Web site at www.eip.sc.gov, then choose your category and select "Online Directories," or go directly to www.apshealthcare.com. Once you are on APS' Web site, click on "Employer Clients" in the top menu bar. Next select "South Carolina" from the drop down list. Then click on "Connect to the Online Provider Locator." You will need to enter SHP's access code, which is "statesc" (all lower case). Finally, click on "Accept."

- You will then be able to search the directory by entering a provider's name or a geographic area. You also may nominate providers for inclusion in the network. If you would like to view or download the directory, go back to the main South Carolina page and click on "Access the Printable Directories," then enter "statesc."

- APS Helplink™ provides tools to help with behavioral health problems, financial and legal issues, child and eldercare concerns and work/life issues. There are two ways to get to APS Helplink.™ The first is to follow the same instructions you use to get to the provider locator, but scroll down the page and follow the instructions for connecting to APS Helplink.™ The second is to go directly to www.apshelplink.com and follow these directions:

  First-time visitors:
  - At the "First Times Visitor's" box click on "Sign up"
  - If you agree with the disclaimer, click on the "I Agree" button
  - Enter "statesc" in the Company Code field
  - Enter a user name
  - Enter a password
  - Re-enter the same password
  - Enter a phrase to help you remember your password
  - For future reference, write down your user name, password and "statesc"
  - Click on the "Submit" button

Returning visitors:
- Go to the "Returning Visitor's" box
- Enter "statesc" in the Company Code field
- Enter your user name
- Enter your password
- Click on the "Submit" button

- There is no limit to the amount of care you may receive as long as it is authorized as medically necessary. **All services (outpatient office visits, inpatient hospital admissions, etc.) must be precertified by APS Healthcare to be covered.**

- There are no claims to file. Your participating provider is responsible for submitting claims for these services.

- Your participating mental health and substance abuse provider will be required to conduct periodic medical necessity reviews (similar to Medi-Call).

- For claims or customer service assistance for mental health and/or substance abuse care, call APS Healthcare at 800-221-8699.

Mental Health and Substance Abuse Benefits Claims

There are no claims to file when you receive mental health or substance abuse services from a participating provider. These providers are responsible for submitting your claims to APS Healthcare. Remember that no benefits are payable if you receive care from a non-participating provider.

Services Not Covered under the State Health Plan

There are some medical expenses the State Health Plan does not cover. The *Plan of Benefits* document (available in your benefits office) contains a complete listing of all of the exclusions. Some expenses that are not covered are charges for:

- Services or supplies that are not medically necessary and routine procedures not related to the treatment of injury or illness
- Services related to a pre-existing condition in the first 12 months of coverage (or 18 months for late entrants). This may be reduced by any creditable coverage you bring to the Plan.
- Routine physical exams, checkups (except well child care and worksite preventive screenings according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary. (Please note: Under the Savings Plan, an annual physical for each participant age 13 and older is covered.)
- Eyeglasses, contact lenses (unless medically necessary after cataract surgery and for the treatment of keratoconus) and routine eye examinations
- Refractive surgery, such as radial keratotomy, and other procedures to alter the refractive properties of the cornea
- Hearing aids and examinations for fitting them
- Dental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident
- TMJ splints, braces, guards, etc. (Medically necessary surgery for TMJ is covered.)
- Custodial care, including sitters and companions
- Over-the-counter medicine and contraceptive devices
- Services connected with a vasectomy or tubal ligation performed within one year of enrollment; surgery to reverse a vasectomy or tubal ligation
- Services for infertility treatment for subscribers who have had a prior tubal ligation
- Assisted reproductive technologies (infertility treatments), except as noted on page 30 of this section
- Experimental or investigational surgery or medical procedures, supplies, devices or drugs

- Diet treatments, and all weight loss surgery, including, but not limited to the following: gastric bypass or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a results of such procedures or treatment

- Equipment that has a non-therapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement, vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.)

- Supplies used for participation in athletics (that are not necessary for activities of daily living)

- Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless approved by the third party claims administrator

- Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat

- Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests

- Fees for medical records and claims filing

- Food supplements

- Services performed by members of the insured's immediate family

- Acupuncture

- Chronic pain management programs

- Transcutaneous electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain

- Complications arising from the receipt of non-covered services

- Psychological tests to determine job, occupational or school placement or for educational purposes; milieu therapy, or to determine learning disability

- Services or supplies payable by Workers' Compensation or any other governmental or private program (including Employee Assistance Program services)

- Charges for treatment of illness or injury or complications caused by acts of war or military service, injuries received by participating in a riot, insurrection, felony or any illegal occupation

- Intentionally self-inflicted injury that does not result from a medical condition or domestic violence

- Cosmetic goods, procedures or surgery or complications resulting from such procedures or services

- Nicotine patches used in smoking cessation programs, as well as prescribed drugs used to alleviate the effects of nicotine withdrawal

- Vocational rehabilitation, pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant), behavior therapy, including speech therapy associated with behavior, cognitive retraining, community re-entry programs or long-term rehabilitation after the acute phase of treatment for the injury or illness

- Congenital anomaly is not covered unless the covered person has been continuously covered under the Plan from birth until the time of treatment

- Sclerotherapy, including injections of sclerosing solutions for varicose veins of the leg, unless a prior approved ligation or stripping procedure has been performed within three years and documentation establishes that some varicosities remained after the prior procedure

- Animals trained to aid the physically challenged

- Abortions, except for an abortion performed in accordance with federal Medicaid guidelines

- Pregnancy of a covered dependent child

Additional Exclusions under the Savings Plan

- **Chiropractic benefits, under the Savings Plan only, are limited to $500 per covered person after the annual deductible is met.**

- **Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.**

What if my Claim or Request for Pre-authorization is Denied?

The Employee Insurance Program contracts with three companies, BlueCross BlueShield of South Carolina, Medco and APS Healthcare, Inc., to administer your SHP benefits. You have the right to appeal their decisions. This is how to appeal:

If all or part of your claim, or a request for precertification is denied, you will be informed of the decision promptly and told why it was made. If you have questions about the decision, first check the information in this book, or call the company that made the decision for an explanation.

If you are unsure whether the decision was fair, you can ask the company to re-examine its decision. This request for review should be in writing and should be made within six months after notice of the decision. If you wait too long, the decision will be considered final.

If you are still dissatisfied after the decision is re-examined, you may ask EIP to review the matter by making a written request to EIP within 90 days of notice of the denial. If the denial is upheld by EIP, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001).

If you Need Assistance or More Information

If you have questions about your benefits, here is how to reach the people with the answers:

Medical

BlueCross BlueShield has a special unit dedicated to processing SHP medical claims, and representatives are available to help you.

You can ***visit the Web site*** sponsored by BlueCross BlueShield at: www.southcarolinablues.com — It gives you access to lists of providers. You can review your claims status, check the status of requests for authorization, see what you have paid toward your deductible, request a new ID card and more.

You can ***call*** BlueCross BlueShield at:
In Columbia 803-736-1576
Nationwide 800-868-2520

You can ***write*** to BlueCross BlueShield at:
State Group Processing Unit
BlueCross BlueShield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605.

Prescription Drugs

Medco has a special unit dedicated to processing SHP prescription drug claims, and representatives are available to help you.

You can ***visit the Web site*** sponsored by Medco at: www.medco.com — It gives you a list of network pharmacies, drug prices and information about drugs. You can also refill prescriptions and learn more about health and wellness.

You can ***call*** Medco at:
800-771-3450

You can ***write*** to Medco at:
Medco Prescriptions
P.O. Box 2277
Lee's Summit, MO 64063-2277

Mental Health/ Substance Abuse

APS Healthcare, Inc., has a special unit dedicated to processing SHP mental health and substance abuse claims, and representatives are available to help you.

You can ***visit the Web site*** sponsored by APS Healthcare at: www.apshealthcare.com — It gives you access to the list of mental health providers, enables you to nominate a provider and gives you information to help you deal with issues related to behavioral health. Choose "Employer Clients" in the top menu bar and then "South Carolina" from the drop-down menu. The access code is "statesc," in lower case letters.

You can ***call*** APS Healthcare at:
800-221-8699

You can ***write*** to APS at:
APS Healthcare, Inc.
Claims, State of SC
P.O. Box 1307
Rockville, MD 20849

Employee Insurance Program

If you need additional help, you can *visit the Web site* sponsored by EIP at: www.eip.sc.gov — This site helps you make the best use of your insurance coverage by providing links to claims processors, FAQs, news and updates, forms and more.

You can ***call*** EIP
803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside the Columbia area)

You can ***write*** EIP at:
Employee Insurance Program
1201 Main Street, Suite 300
P.O. Box 11661
Columbia, SC 29211